No. 86-1764

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In The
Supreme Court of the United States
October Term, 1987

BETHESDA HOSPITAL ASSOCIATION and the DEACONESS HOSPITAL OF CINCINNATI, OHIO,
Petitioners,

v.

OTIS R. BOWEN, M.D., Secretary of Health and Human Services,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE SIXTH CIRCUIT

BRIEF AMICUS CURIAE OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PETITIONERS

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QUESTIONS PRESENTED

1. Whether providers of health care services covered by the Medicare Act who have complied with applicable agency regulations and instructions in preparing required cost reports thereby forfeited their right to challenge the validity of such a regulation.

2. Whether the Secretary of Health and Human Services may impose requirements that operate to deny administrative and judicial review under the Medicare Act when the statute itself contains no such requirement.

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INTEREST OF THE AMERICAN HOSPITAL ASSOCIATION

Amicus Curiae American Hospital Association ("AHA") respectfully submits this brief in support of the Petitioners. The AHA has obtained the written consent of both the Petitioners and the Respondent to the filing of this brief *amicus curiae*.

The AHA is a not-for-profit membership corporation organized under the laws of the State of Illinois, and is the primary organization of hospitals in the United States.

Its membership includes approximately 6,000 hospitals and other health care institutions, as well as approximately 45,000 individuals. The principal corporate objective of the AHA is "[t]o promote high quality health care and health services for all the people through leadership . . . [and assistance to] hospitals and health care organizations in meeting the health care needs of their communities."

The overwhelming majority of AHA's institutional members are certified to participate in the Medicare program, Title XVIII of the Social Security Act, 42 U.S.C.§§1395 *et seq.*, and provide inpatient hospital services to Medicare beneficiaries pursuant to a provider agreement with the Secretary of Health and Human Services ("Secretary"). Accordingly, the AHA is vitally concerned with promoting sound government policies and procedures affecting the administration and integrity of the program, including policies, procedures, and requirements for reimbursement of the costs of providing services to Medicare patients. This case involves the legitimacy of attempts by an agency to deny providers both administrative and judicial review of agency actions which substantially impact those providers and for which Congress itself has provided review.

Although Medicare payment is now administered under a prospective payment system (not essentially material to the case at bar), at the time this matter arose a retrospective reimbursement system was in effect. Under that system, hospitals certified to participate in the Medicare program were generally reimbursed the "reasonable cost" of providing services to Medicare patients. 42 U.S.C. §1395x(v)(1)(A). The final determination of those "reasonable costs" for subject years is made at the end of a hospital's cost-reporting period ("cost year"). 42 C.F.R. §405.406 (1980).

The process of retrospective reimbursement is initiated when a hospital submits a request for payment of its

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costs incurred in providing services to Medicare patients by filing a "cost report."[1] A cost report should include every cost incurred by the hospital for every activity in which it engages. The cost report separates reimbursable from non-reimbursable costs and, with respect to those that are reimbursable, apportions costs between Medicare and non-Medicare patients. By completing the cost report according to the Secretary's instructions and regulations, the hospital calculates its Medicare reimbursable costs.

The hospital files its completed cost report with the "fiscal intermediary," a private entity operating under contract with the Secretary. The fiscal intermediary's primary function is to audit the hospital's cost report and prepare a written notice reflecting the intermediary's determination of the total amount of reimbursement due to the provider (called a Notice of Program Reimbursement ("NPR")). 42 C.F.R. §405.1803 (1986). *See also* S. Rep. No. 404, 89th Cong., 1st Sess., *reprinted in* [1965] U.S. Code Cong. & Ad. News 1943, 1992-95; *Heckler v. Community Health Services of Crawford County;* 467 U.S. 51, 104 S. Ct. 2218, 2226 (1984). As noted by the court in *Baptist Hospital East v. Secretary of HHS*, 802 F. 2d 860, 864 (6th Cir. 1986), "the intermediary has no authority to alter the Secretary's regulations governing reimbursement but must faithfully apply them as they stand."

In order to obtain administrative review by the Provider Reimbursement Review Board ("PRRB") of reimbursement determinations by the fiscal intermediary, a hospital must meet the jurisdictional requirements of 42

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[1]The cost report is a voluminous document with schedules, worksheets, and supplemental worksheets. The Provider Reimbursement Manual (HIM-15) specifies which schedules and worksheets must be filed by each type of provider with its fiscal intermediary. The ultimate array of constituent schedules and worksheets is determined by such questions as whether the provider is for-profit or not-for-profit, and which services it furnishes.

U.S.C. §1395oo. Pursuant to 42 U.S.C. §1395oo(a), any provider that has timely filed a required cost report "may obtain a hearing with respect to such cost report" by the PRRB if that provider "is dissatisfied with a final determination of...its fiscal intermediary...as to the amount of total program reimbursement due the provider...." Further, the PRRB has the authority to make revisions on all matters "covered by such cost report...even though such matters were not considered by the intermediary in making such final determination." 42 U.S.C. §1395oo(d). Despite the clear and controlling statutory language, the PRRB in this case refused jurisdiction over Petitioners' claims because, in its view, Petitioners had failed to present a "claim" to the fiscal intermediary sufficient to notify it of a "dispute" over a cost item.

The court below held that the PRRB properly refused jurisdiction, 810 F. 2d at 561, reasoning that pursuant to that court's previous holding in *Baptist Hospital*, submission of a "claim" before the fiscal intermediary is a prerequisite for PRRB and judicial review. *Id.* at 561-62. Petitioners' problem was due to the fact that they had completed their 1980 and 1981 cost reports *in compliance with* the Secretary's regulation and instructions concerning medical malpractice insurance costs, thus "self-disallowing" their claims for reimbursement of costs in excess of those allowed under the Secretary's regulation (42 C.F.R. §405.452(b)(1)(ii) (1979) ("the 1979 Malpractice Rule"). *See Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435, 1442 n.10 (11th Cir. 1987), *petition for cert. filed* (U.S. Sept. 2, 1987) (No. 87-380) (definition of "self-disallowance"). Yet at the time Petitioners completed their cost reports, they had no notice that compliance with the 1979 Malpractice Rule and relevant instructions would operate as a waiver of their right to be heard or to challenge the regulation itself. Moreover, the language of the cost report explicitly warns that misrepresentation of data on the report may be punishable by fine

or imprisonment. Many hospitals are necessarily reluctant to claim costs that are expressly non-allowable under Medicare regulations, given the potential application of the anti-fraud provisions found in 42 U.S.C. §§1320a-7(a), (b); 1320a-7a. Those statutes prescribe both criminal and civil money penalties against any person who files a false claim under the Medicare program.

The question whether the PRRB has jurisdiction to consider self-disallowed claims affects all types of Medicare providers that seek access to administrative and judicial review. The resolution of the issues presented in this case is thus of great importance to AHA member hospitals and other providers of services, including skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities.

For hospitals, this issue has continuing significance notwithstanding the advent of the Medicare prospective payment system ("PPS") (effective October 1, 1983), under which hospitals receive a fixed amount per Medicare discharge, depending on the patient's diagnosis. There are hospitals exempt from PPS (*e.g.*, children's hospitals, psychiatric hospitals), which still receive cost reimbursement on the basis of their filed cost reports, and all their costs are subject to appeal to the PRRB. And even those hospitals covered by PPS receive, for the first four years, interim rates based in part on a cost report filed in an earlier "base year," generally fiscal year 1982. Disputes concerning the base year cost report (including the self-disallowance issue) are still in the administrative and judicial review process, and the result of those appeals will materially affect the hospitals' PPS rates. *See* Kinney, *The Medicare Appeals System for Coverage and Payments Disputes: Achieving Fairness in a Time of Restraint*, 1 Admin. L.J. 1, 44 (1987) ("irrespective of what transpires under the prospective payment system, the [PRRB] anticipates that it will continue to hear a high volume of hospital appeals until well beyond

1987"). Also, these PPS hospitals continue to receive payment for certain costs on a cost reimbursement basis, which depends on the filing of cost reports in each PPS year.[2]

With respect to implementation of the prospective payment system, PRRB review of all provider costs incurred during the base year is essential to ensure that providers receive accurate payments. The amount paid under prospective payment constitutes the total payment by the Medicare program for hospital operating costs attributable to all items and services furnished to Medicare inpatients. The prospective payment amount is determined, in part, for each hospital based upon the total Medicare allowable cost for the hospital's base year (generally, cost reporting periods ending on or after September 30, 1982, and before September 30, 1983). Hence, costs that are not allowable during a provider's base year will reduce the Medicare payment amounts under PPS. PRRB jurisdiction to review all of the provider's costs incurred during the base year therefore affects not only the provider's particular fiscal year in question, but also that provider's subsequent fiscal years under PPS. Accurate determination of base year amounts will help ensure that the amounts paid under the prospective payment system accurately reflect the costs for services provided to Medicare beneficiaries.

This case also raises a broader question, of particular importance to the AHA and its membership: the soundness, fairness and consistency of governmental action affecting the rights of providers. At issue here is the Secretary's unwritten policy requiring that Medicare providers transgress stated procedures governing cost reporting in order to obtain administrative and judicial review. Such a

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[2] In addition, many non-hospital providers are cost-reimbursed based on filed cost reports, and are entitled to appeal their cost reimbursement disputes to the Board. The self-disallowance issue can arise in any of these appeals.

"policy" is both unreasonable and in conflict with the controlling language of the Medicare Act itself. AHA suggests that this Court should reject this manifestly unjust denial of review and should adopt the reasoning of those United States Courts of Appeals that have recognized jurisdiction in the PRRB. *Adams House Health Care v. Heckler*, 817 F. 2d 587 (9th Cir. 1987); *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services*, 698 F. 2d 1337 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983). See also *Tallahasee Memorial Regional Medical Center v. Bowen*, 815 F. 2d 1435 (11th Cir. 1987), (jurisdiction exists when hospital seeks to challenge Medicare regulation).

SUMMARY OF THE ARGUMENT

Governmental policies and procedures affecting providers' ability to obtain review of matters covered by their cost reports affects directly their right to appropriate reimbursement and can affect their continued ability to provide needed services to Medicare beneficiaries. *Amicus curiae* American Hospital Association respectfully submits that the judgment of the United States Court of Appeals for the Sixth Circuit below denying PRRB jurisdiction over self-disallowed claims should be reversed for the following reasons. First, and contrary to the interpretation by the Secretary, the language of the Medicare statute itself clearly provides for PRRB review of self-disallowed costs. Second, the Secretary's interpretation in any event is not entitled to deference because it is outside any area of his expertise and is contrary to the strong presumption of judicial reviewability of administrative actions. Finally, the Secretary's construction of the statute is not entitled to deference because it is both arbitrary and capricious.

I. THE MEDICARE STATUTE CLEARLY PROVIDES FOR ADMINISTRATIVE AND JUDICIAL REVIEW IN THE INSTANT CASE

This case involves the proper construction of 42 U.S.C. §1395oo, that provision of the Medicare Act which governs review of provider cost reports by the PRRB. Review by the PRRB is a prerequisite to judicial review of claims, except in cases where direct appeal to federal district court is provided to challenge a law or regulation. 42 U.S.C. §1395oo(f).[3]

The specific question presented is whether the PRRB has jurisdiction to review reimbursement claims for items included in a cost report but not disallowed by the fiscal intermediary because Petitioners complied with the Secretary's regulation and cost report instructions. The language of the controlling statute makes plain that jurisdiction does exist. Specifically, subsection (a) of 42 U.S.C. §1395oo provides, in relevant part, that:

> Any provider of services which has filed a required cost report . . . may obtain a hearing with respect to such cost report by a Provider Reimbursement Review Board . . . , if –
>
> (1) such provider –
>
> (A)(i) is dissatisfied with a final determination of . . . its fiscal intermediary . . . as to the amount of total program reimbursement due the provider . . . for the period covered by such report . . .

[3] In 1980, Congress amended § 1395oo(f) to create a new avenue of judicial review. Congress inserted into § 1395oo(f) a method to bypass parts of the administrative process when a question of law or regulations was in controversy. Omnibus Reconciliation Act of 1980, Pub. L. No. 96-499, § 955, 94 Stat. 1569, 2647-48. The legislative history makes clear that this change was in recognition of the futility of requiring the PRRB to conduct a full review of these challenges when it has no authority to rule on the issue. H.R. Rep. No. 1167, 96th Cong., 2d Sess. 394, *reprinted in* 1980 U.S. Code Cong. & Ad. News 5526, 5757.

The scope of the review by the PRRB is prescribed by 42 U.S.C. §1395oo(d) and is equally explicit in its relevant terms:

> The [PRRB] shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report (including revisions adverse to the provider of services) even though such matters were not considered by the intermediary in making such final determination.

Subsections (a) and (d) of 42 U.S.C. §1395oo must be read together. The intermediary's final determination in this case is the NPR that was issued by the intermediary to the Petitioners. The NPR reflects the *total* amount of reimbursement to which a provider is entitled. As such, all that is required is provider dissatisfaction with the total reimbursable amount, as opposed to an intermediary's specific adjustments.

As noted by the Ninth Circuit in *Adams House Health Care v. Heckler*, 817 F.2d 587 (9th Cir. 1987), subsection (a) does not require that a provider be dissatisfied with an "intermediary determination as to specific costs. Rather, this subsection . . . requires that a provider be dissatisfied with the total amount of reimbursement offered by an intermediary, not with the intermediary's reasoning process with respect to any specific costs." 817 F.2d at 592. Furthermore, a provider's failure to claim certain costs at the intermediary level does not reflect fault or negligence on the part of the provider when it would have been pointless to do so because the intermediary has no authority to deviate from the regulations. *Id.*

While subsection (a) sets forth the general jurisdiction of the PRRB to determine provider reimbursement disputes, subsection (d) provides the statutory framework for the PRRB's authority once jurisdiction has been estab-

lished. In this regard, Congress granted the PRRB expansive authority over cost reports that are the subject of dispute. The statute provides that the PRRB "shall have the power to affirm, modify, or reverse a final determination of the fiscal intermediary with respect to a cost report and to make any other revisions on matters covered by such cost report . . . ." 42 U.S.C. § 1395oo(d).

There is nothing in the statutory grant of authority that limits the PRRB review to specific cost items in dispute as reflected by an intermediary audit adjustment. Indeed, the statute also specifies that the PRRB may make "revisions on matters covered by . . . [a] cost report . . . even though such matters were not considered by the intermediary in making such final determination." *Id.* As the Seventh Circuit Court of Appeals has found "since the statute allows the Board to consider matters outside the cost reports . . . the Provider Reimbursement Review Board [has] the authority to consider whether the costs . . . are reimbursable under the Medicare Act." *St. Mary of Nazareth Hospital Center v. Department of Health and Human Services, et al.*, 698 F.2d 1337, 1346 (7th Cir.), *cert. denied*, 464 U.S. 830 (1983).

Clearly, the Petitioners' malpractice insurance costs are matters covered by the cost report. Providers' malpractice insurance costs are referenced in several worksheets included as part of the cost report. Additionally, even though the intermediary did not "consider" certain malpractice costs because the providers followed the Medicare regulations in apportioning their costs, the PRRB has the authority to make revisions to these "matters."

As concluded by the Ninth Circuit in *Adams House*, the Medicare statute is not puzzling or ambiguous. "On the contrary, it plainly requires the Board to consider matters included in a cost report and timely appealed, even if not expressly claimed before an intermediary." 817 F.2d at 594. In the current case, the Petitioners' mal-

practice insurance costs have been included in respective cost reports that were timely filed and appealed to the PRRB. Accordingly, AHA submits that the statute clearly and unambiguously provides for administrative and judicial review, even though the providers followed Medicare program regulations and "self-disallowed" the malpractice costs at issue.

Moreover, the Eleventh Circuit has held that 42 U.S.C. § 1395oo(f) provides a further avenue of judicial review for providers that self-disallow reimbursable costs. In *Tallahassee Memorial Regional Medical Center v. Bowen*, 815 F.2d 1435 (11th Cir. 1987) five hospitals of a larger group that had contested the application of the 1979 Malpractice Rule, followed the directives of the 1979 Medicare malpractice regulation, thereby self-disallowing the desired pre-1979 reimbursement. *Id.* at 1457. In holding that these self-disallowing hospitals were entitled to judicial review, the *Tallahassee* court focused on the grant of review contained in the third through sixth sentences of § 1395oo(f). These sentences permit a provider to obtain expedited judicial review of a Medicare reimbursement dispute when the provider is challenging the validity of a Medicare regulation and the PRRB determines that it is without authority to decide the question.[4] The *Tallahassee* court also held that if a provider meets the requirements of subsection (a), it is entitled to judicial review even with respect to costs that were self-disallowed on the cost report. The court held that the grant of judicial review in subsection (f) did not concern *decisions* of the PRRB and thus the provisions of § 1395oo(d) were not relevant. *Id.* at 1461.

Because it found that § 1395oo(d) was not relevant, the Eleventh Circuit was able to distinguish the adverse decision of the D.C. Circuit, *Athens Community Hospital, Inc. v. Schweiker (Athens* II), 743 F.2d 1 (D.C. Cir. 1984),

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[4] *See* note 3, *supra* at p. 8.

as well as the *Baptist Hospital* decision which was relied upon by the court below in this case. 815 F.2d at 1462-63.[5]

As noted above, the providers in this case also requested expedited judicial review pursuant to amended § 1395oo(f), but were denied their request because they self-disallowed their malpractice insurance costs. However, because these providers have met the basic jurisdictional criteria of subsection (a) of 42 U.S.C. § 1395oo, denial of jurisdiction on the basis of subsection (d) is inappropriate.

II. THE SECRETARY'S CONSTRUCTION OF THE STATUTE IS NOT ENTITLED TO DEFERENCE

The Secretary's interpretation, which denies Petitioners' clear statutory right to PRRB review of self-disallowed claims, is not entitled to deference. This Court has clearly stated the standard of review that should be applied in this context:

> "[T]he question [first is] whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter for the court, as well as the agency, must give effect to the unambigously expressed intent of Congress."

Chevron, U.S.A., Inc. v. National Resources Defense Council, Inc., 467 U.S. 837, 842 (1984). Only if the statute were unclear, or where Congress has implicitly or explicitly delegated authority to the agency, must the question of agency interpretation be reached. *Chevron*, 467 U.S. at 843-44. *See INS v. Cardoza-Fonseca*, 107 S. Ct. 1207, 1225 (1987) (Scalia, J. concurring) (reasonableness of agency

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[5]The Eleventh Circuit's opinion also adequately distinguishes Petitioners' situation from that confronted by the court in *North Broward Hospital District v. Bowen*, 808 F.2d 1405 (11th Cir. 1987), *petition for cert. filed* (U.S. May 26, 1987)(No. 86-1986.)

interpretation of statute remains test post-*Chevron*). Further, if this Court were to question the plain language of the statute, the fact remains that the Secretary's interpretation is not entitled to deference because it is outside any area of the Secretary's expertise and is contrary to the strong presumption of reviewability of administrative determinations.

A. The Secretary's Construction of the Statute is Not Entitled to Deference Because it is Outside Any Area of His Expertise

The Secretary's construction of the statute requires him to interpret a question of law and thus is not entitled to deference because it is clearly outside his area of expertise. Although the interpretation put on a statute by the agency charged with administering it is entitled to deference in some circumstances, the courts remain the final authorities on issues of statutory construction. *FEC v. Democratic Senatorial Campaign Committee*, 454 U.S. 27, 31-32 (1981). Indeed, in *Volkswagenwerk v. Federal Maritime Comm'n*, 390 U.S. 261 (1968), Justice Stewart, writing for the Court, cautioned against placing too much weight upon the agency's interpretation:

> Courts . . . are not obliged to stand aside and rubber-stamp their affirmance of administrative decisions that they deem inconsistent with a statutory mandate or that frustrate the congressional policy underlying a statute . . . The deference owed to an expert tribunal cannot be allowed to slip into a judicial inertia.

390 U.S. at 272 (citations omitted). As this Court has further recognized, even when deference is appropriate the extent of deference is controlled by the circumstances of the case: "Varying degrees of deference are accorded to administrative interpretations, based on such factors as . . . the nature of its expertise." *Batterton v. Francis*, 432 U.S. 416, 425 n.9 (1977) (citations omitted).

While courts avoid substitution of judgment for that

of the agencies in areas in which the agency is especially qualified, courts are generally better qualified than agencies to resolve questions of law. K. Davis, *Administrative Law Treatise* § 29.00-1 (Supp. 1982). Deference is appropriate only when "the agency is interpreting its own statute in a technical and complex area." *Southern Motor Carriers Rate Conference v. United States*, 773 F.2d 1561 (11th Cir. 1985). The jurisdictional issue before this Court does not require the application of the agency's health care or accounting expertise; rather, it is purely a question of law for the courts to decide. *Adams House*, 817 F.2d at 594.

Within this context the analysis of the D.C. Circuit in *Washington Hospital Center v. Bowen*, 795 F.2d 139 (D.C. Cir. 1986), seems particularly apt:

> A second consideration regarding interpretation of Congressional intent is the fact that §1395oo(a) deals with procedures for challenging agency actions, not the substance of those actions .... In general, Congress is less likely to delegate interpretive authority to agencies on basic procedural matters–such as rights to access to challenge or obtain judicial review of agency rulings–than it is to substantive matters such as when and what to regulate.

Id. at 147 n.10. As the *Washington Hospital* court noted, *id.* at 147-148 n.10, this Court has recently rejected the Secretary's interpretations of statutory provisions governing judicial review. *Bowen v. Michigan Academy of Family Physicians*, 476 U.S. 667 (1986); *Bowen v. City of New York*, 476 U.S. 467, n.10 (1986). Clearly, the Secretary has no inherent expertise in this area. While the PRRB may possess special expertise in interpreting and applying substantive provisions of the Medicare statutory scheme, unlike courts it has no special expertise at interpreting provisions governing jurisdiction. *Adams House*, 817 F.2d at 594. This Court should thus similarly reject the Secretary's interpretation of the extent of 42 U.S.C. § 1395oo's grant of administrative and judicial review.

Furthermore, here the Secretary is interpreting his own power to review determinations by his fiscal intermediary. It is a policy of questionable merit to allow an agency to "interpret" those portions of a statute governing its own power:

> [T]his rule [deference to agency interpretation] should not be applied to an administrative construction involving the administrator's own powers. Surely it would be a strange doctrine that would permit an administrative officer to extend his own powers in doubtful cases by his own interpretation of the statute. It would be a clear case of lifting oneself by one's own bootstraps.

Stark v. Brannan, 82 F. Supp. 614, 618 (D.D.C. 1949), *aff'd*, 185 F.2d 871 (D.C. Cir. 1950), *aff'd*, 342 U.S. 451 (1952).

It is especially inappropriate to defer to the Secretary's interpretation here because, since the beginning of the Medicare program, the agency has shown a pattern of reluctance to allow both administrative and judicial review of disputes regarding claims for reimbursement under the Medicare Act. *See Coral Gables Convalescent Home v. Richardson*, 340 F. Supp 646 (S.D. Fla. 1972) ("this Court, like the Second Circuit in *Acquavella v. Richardson*, 437 F.2d 397 (2d Cir. 1971) is disconcerted by defendants' contention that plaintiff is entitled to neither administrative nor judicial review . . . ").

For instance, the Secretary initially offered no disputes resolution process for providers aggrieved by the level of Medicare reimbursement. Even when the Secretary fashioned a somewhat formalized dispute resolution process consisting of a "hearing" before a panel established by the provider's intermediary, 20 C.F.R. §§ 405.490-499(i) (1974), the agency again strenuously resisted provider access to the federal courts following this hearing process. *See, e.g., Temple University v. Associated Hospital Service*, 361 F. Supp. 263 (E.D. Pa. 1973); *Sacred Heart Hospital v. United States*, 616 F. 2d 477, 482 (Ct. Cl. 1980) ("Defen-

dant once again challenges this Court's jurisidiction over a portion of this Medicare case. As to the years 1967 through fiscal year 1972, defendant apparently finally accepts this Court's jurisdiction . . .").

This bias against judicial review continues to be evidenced in other Medicare-related contexts as Congress makes additional changes to the program. In *Memorial Hospital v. Heckler*, 706 F. 2d 1130 (11th Cir. 1983), *cert. denied*, 465 U.S. 1023 (1984), the Court rejected an assertion by the Secretary that 42 U.S.C. § 1395oo(g) prevented judicial review of a claim for reimbursement for patient telephones where the Secretary's regulations listed telephones as an example of noncovered personal comfort items under 42 U.S.C. § 1395y.

More recently, in *Washington Hospital Center v. Bowen*, 795 F.2d 137 (D.C. Cir. 1986), the court was faced with the Secretary's assertion that changes made to 42 U.S.C. § 1395oo(a) regarding PRRB jurisidiction to review disputes under the prospective payment system precluded PRRB review until after the Notice of Program Reimbursement was issued. The court rejected this argument because it found Congressional intent clear to eliminate the NPR requirement for PPS appeals. 795 F. 2d at 146.

Perhaps, then, it is not surprising that the agency would include as a prerequisite for administrative (and judicial) review of self-disallowed claims the additional requirement that providers expressly "claim" the cost as a reimbursable item on their cost reports in order to obtain administrative and judicial review even though to do so violates existing rules and regulations. Certainly the concept and term "self-disallowance" is not found in Medicare statutes or regulations.[6] The Secretary's interpretations of jurisdictional grants reflect an established bias against

[6] *Tallahassee Memorial*, 815 F.2d at 1442 n. 10. *See also* Part I, *supra* at pp. 8-12.

such grants, which substantially undermines the deference that should be accorded to his interpretation of the statute.

B. The Secretary's Construction of the Statute is Not Entitled to Deference Because it is Contrary to the Strong Presumption of Reviewability of Administrative Actions

Furthermore, the Secretary's interpretation of the statute should not be accorded deference because it runs counter to the strong presumption of reviewability of administrative actions. In the previously discussed *Memorial Hospital Center v. Heckler* case, the Court stated:

> To expand the non-reviewability of intermediary decisions to include policy decisions of the Secretary would not merely insulate from judicial scrutiny the finding of an intermediary. It would give the Secretary virtually unbridled discretion to prevent reimbursement through regulations. Such a result would run contrary to the presumption favoring judicial review. *See Abbott Laboratories v. Gardner*, 387 U.S. 136, 141, 87 S.Ct. 1507, 1511, 18 L. Ed. 2d 681 (1967). ("[O]nly upon a showing of clear and convincing evidence of contrary legislative intent should courts restrict access to judicial review."); *Derring L. Melliken, Inc. v. Occupational Safety & Health Review Comm.*, 630 F. 2d 1094, 1099 (5th Cir. 1980).

Id. 706 F. 2d at 1133. Reliance upon the presumption of reviewability to rebut or eliminate an inference of non-reviewability where it was not required by the plain language of the statute is equally applicable in the case of self-disallowed costs. In *Bowen v. Michigan Academy of Family Physicians*, this Court again addressed this presumption. There the Court stated:

> The presumption of judicial review is, after all, a presumption and like all presumptions used in interpreting statutes, may be overcome by, *inter alia*, specific language or specific legislative history that is a reliable indicator of congressional

> intent to preclude judicial reviews that is fairly discernable in the detail of the legislative scheme.

106 S. Ct. at 2137. Although this Court indicated that it was basing its review in *Michigan Academy* generally upon the premise that "only upon a showing of 'clear and convincing evidence' of contrary legislative intent should the courts restrict access to judicial review," *id.*, *citing Abbott Laboratories v. Gardner*, 387 U.S. at 141, the Court did in fact apply that standard. Certainly there is no clear and convincing evidence in this case that a self-disallowance of reimburseable costs should restrict access to administrative and judicial review.

C. The Agency's Inconsistent Application of the Statute Demonstrates the Arbitrariness and Capriciousness of the Secretary's Current Interpretation

Because the Secretary has interpreted the statute in an inconsistent manner, his current interpretation is suspect. *INS v. Cardoza-Fonseca*, 107 S. Ct. at 1231 n.30 (1987) (an agency's interpretation which conflicts with a prior interpretation is also entitled to considerably less deference). For example, in *St. Luke's Hospital v. Secretary of Health and Human Services*, 810 F.2d 325, 331 (1st Cir. 1987), the First Circuit pointed to at least four cases in which the PRRB accepted jurisdiction over self-disallowed cases.

In addition, the Eleventh Circuit has considered the merits of another case in which the PRRB originally exercised jurisdiction over self-disallowed costs. In *Charter Peachford Hospital, Inc. v. Bowen*, 803 F. 2d 1541 (11th Cir. 1986), the Court of Appeals specifically noted: "Although Charter Peachford did not originally claim reimbursement for the salaries on its 1980 cost report, it later appealed the intermediary's disallowance of these costs to the Provider Reimbursement Review Board." *Id.* at 1543. Despite the factual similarities between *Charter*

and the instant case, the PRRB did not deny jurisdiction in *Charter* and the Secretary apparently raised no jurisdictional objections, thereby calling into question the consistency of application of the Secretary's narrow "interpretation" of the Medicare jurisdictional statute to preclude appeals by "self-disallowing" hospitals.

The PRRB held that it did not have jurisdiction to hear the Petitioners' self-disallowed claims because they had not overtly claimed these costs before the fiscal intermediary. Nowhere in the statute is there a requirement that a hospital must provide separate "notice" of a dispute to the intermediary in order to obtain further review by the PRRB. Furthermore, the Secretary has promulgated no regulation informing hospitals of his narrow view of their appeal rights. This violates any concept of reasonable and fair "notice" as embodied in the Administrative Procedure Act ("APA"). 5 U.S.C. § 551 *et seq.* The APA requires the promulgation of all substantive rules of general applicability and statements of general policy or interpretations of general applicability. 5 U.S.C. § 552(a)(1). Absent actual and timely notice of the terms of such rules and policies, regulated entities cannot be required to resort to, or be adversely affected by, such rules and policies. *Id.* Binding interpretations and those which "foreclose alternative courses of action or conclusively affect rights of private parties" must be promulgated pursuant to 5 U.S.C. § 553. *Linoz v. Heckler*, 800 F. 2d 871, 877 (9th Cir. 1986).[7]

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[7] Even were the Secretary to promulgate a regulation indicating that providers must comply with a given requirement or forfeit their appeal rights, the validity of that regulation would be suspect because of conflict with the Medicare statute itself. The language of the statute is clear, and imposes no notice requirement as a prerequisite for judicial review. *See* Part I, *supra*. at pp. 7-12.

CONCLUSION

For the reasons set forth above, AHA respectfully submits that the decision of the court of appeals should be reversed.

Respectfully submitted,

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